

**BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO**

CLARE AGUE,	)	
	)	
Claimant,	)	
	)	
v.	)	<b>IC NO. 04-510461</b>
	)	
IDAHO HOUSING & FINANCE	)	
ASSOCIATION,	)	
	)	
Employer,	)	<b>FINDINGS OF FACT,</b>
	)	<b>CONCLUSIONS OF LAW,</b>
and	)	<b>AND RECOMMENDATION</b>
	)	
STATE INSURANCE FUND,	)	Filed: September 29, 2005
	)	
Surety,	)	
Defendants.	)	
_____	)	

**INTRODUCTION**

Pursuant to Idaho Code § 72-506, the Idaho Industrial Commission assigned the above-entitled matter to Referee Rinda Just, who conducted an emergency hearing in Lewiston, Idaho, on May 20, 2005. Michael Kessinger of Lewiston represented Claimant. Gardner W. Skinner, Jr., of Boise represented Defendants. The parties submitted oral and documentary evidence. By agreement of the parties, the hearing was continued to June 20, 2005, at which time additional testimonial and documentary evidence was admitted. Two post-hearing depositions were taken and the parties submitted post-hearing briefs. The matter came under advisement on August 10, 2005, and is now ready for decision.

**ISSUES**

By agreement of the parties at hearing, the issues to be decided are:

1. Whether the condition for which Claimant seeks benefits was caused by the May 11, 2004 accident; and

2. Whether and to what extent Claimant is entitled to additional medical care.

### **CONTENTIONS OF THE PARTIES**

Claimant asserts that she sustained an injury on May 11, 2004 when she tried to move an empty filing cabinet at her place of employment. Initially, she experienced pain on the right side of her neck and across the top of her right shoulder, but eventually the pain involved her right arm as well. When conservative treatment, including physical therapy, epidural steroidal injections and narcotic analgesics, did not alleviate her pain, her treating physicians recommended a diagnostic discogram, which was denied by Surety.

Defendants dispute that the conditions for which Claimant seeks treatment are related to a work-place accident; even if there had been an injury as a result of moving a filing cabinet at work, that injury is not responsible for Claimant's current symptoms. Further, Defendants argue that neither of Claimant's treating physicians has determined that a diagnostic discogram is "required" and therefore Defendants are not obligated to pay for the test.

### **EVIDENCE CONSIDERED**

The record in this matter consists of the following:

1. Testimony of Claimant, Kit Ague, Tanya Wassmuth, and Frederick Miller offered at hearing;

2. Claimant's Exhibits 1 through 10 admitted at the hearing;<sup>1</sup>

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<sup>1</sup> The Referee notes that neither Claimant's nor Defendants' exhibits were in compliance with Rule 10(C)(1), J.R.P. Neither set of exhibits was arranged in proper chronological order. Moreover, Defendants' exhibits were not consecutively numbered, and contained numerous medical records that were in no way related to the matters at issue in this proceeding. These extraneous medical records were not only irrelevant, but were intensely private in nature, and

3. Defendants' Exhibits 1 through 15 admitted at the initial hearing, with the following exceptions, which the Referee strikes, *sua sponte*, as being irrelevant in the extreme:

- Ex. 6b, report dated 10/12/95; Ex. 6c, report dated 3/9/98; Ex. 6g, report dated 2/9/01; Ex. 6h, and 6i, reports dated 4/25/01; Ex. 6j, report dated 8/29/02; Ex. 6k, report dated 5/3/04;
- The following documents contained in Ex. 11: letter dated 5/20/04 from Brian Page, M.D. to Jeffrey R. Pedersen, M.D.; notes dated 12/21/00, 2/9/01, 2/15/01, and 3/15/01; note dated 2/23/98; note dated 9/5/97; notes dated 10/9/96, and 10/11/96; notes dated 4/24/96 and 5/7/96; note dated 2/12/96; notes dated 9/6/95, 9/20/95, and 10/11/95; reports dated 7/11/02 at 1541 hrs., and 7/11/02 at 1330 hrs.; report dated 6/11/02; report dated 8/29/02; reports dated 2/27/02 and 2/27/02 at 1511 hrs. (2 pages); report dated 2/19/02; report dated 8/05/01; report dated 2/29/96; report dated 10/13/95; report dated 2/26/98; report dated 4/22/97; report dated 10/12/95; report dated 10/13/95; report dated 2/26/98; report dated 2/27/02; report dated 11/1/96; report dated 9/5/02; report dated 10/19/95; report dated 8/29/02; report dated 2/9/01; report dated 10/25/00; reports dated 4/25/01 at 1748 hrs. and 1115 hrs.; report dated 3/9/98; report dated 9/12/95; reports dated 8/29/02 (operative report, consultation record); operative report dated 3/8/01; consultation record dated 10/16/95 (two pages, same document); operative report dated 10/16/95 (two pages, same document); record dated 9/15/95; letter dated 10/15/96 from Dr. Page to Ron Johnston, M.D.; consultation report dated 10/23/96 (two pages); operative report dated 10/24/96; letter dated 10/28/96 from Dr. Johnston to Dr. Page; corrected letter dated

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never should have been made a part of the record in this matter. It is incumbent upon the party tendering proposed exhibits to review them for relevancy. It is incumbent upon the opposing party to identify and object to tendered exhibits that are clearly beyond the pale in a particular case.

10/28/96 from Dr. Johnston to Dr. Page; letter dated 3/21/01 from Dr. Page to William D. Post, M.D.; letter dated 4/27/01 from Dr. Post to Dr. Page; record dated 10/2/95 (two pages); summary report with test results from 3/94 through 11/02; reports dated 10/30/95, 11/29/95, 1/22/96, 3/1/96, 9/3/97, 3/17/98, and 10/16/00;

➤ The following documents contained in Ex. 12: records (33 pages) from Cranbrook Regional Hospital for the dates of 8/29/02 through 8/30/02; records (19 pages) from Cranbrook Regional Hospital dated 5/8/01; consultation report dated 4/25/01; record dated 12/2/96; record dated 9/15/95; records (21 pages) from Cranbrook Regional Hospital dated 10/16/95; record dated 9/13/95; record dated 9/6/95; record dated 9/3/95; record dated 8/29/94;

➤ The following documents contained in Ex. 13: lab report dated 12/23/02 together with following page.

4. Defendants' Exhibits 8a, 16, and 18 admitted at the continuation of the hearing;
5. Post-hearing depositions of J. Craig Stevens, M.D., and Gary Dean Haas, D.O.;

and

6. The Industrial Commission legal file.

Claimant, in her Reply Brief, sought to have portions of Defendants' Post-hearing Brief struck from the record for failure to comply with Rule 11(B), J.R.P. In particular, Claimant objected to the portion of Defendants' brief headed "Legal Analysis and Argument" because this portion of the brief lacked citations to the record. A review of Defendants' Post-Hearing Brief shows that appropriate citations are used in the portion of the brief headed "Review of the Evidence." Defendants then used that same evidence in the argument and analysis portion of their brief. Re-citing the record in the argument and analysis is an unnecessarily technical

reading of Rule 11(B), and would serve little purpose other than to lengthen an already over-long brief.<sup>2</sup> The Referee declines to strike any portion of Defendants' brief.

After having considered all the above evidence and the briefs of the parties, the Referee submits the following findings of fact and conclusions of law for review by the Commission.

### **FINDINGS OF FACT**

1. Claimant was employed by Idaho Housing and Finance Association as a receptionist at the time of her alleged industrial accident. Employer was in the process of revamping the filing system, which required that all of the file cabinets be emptied. One of the filing cabinets in the front office area was broken and Claimant intended to move the broken cabinet to the back filing room and move a working cabinet to the front office in its place.

### ***THE ACCIDENT***

2. Claimant testified that on May 11, 2004 she was attempting to wriggle the empty broken file cabinet out of its niche between a wall and an adjacent filing cabinet. Claimant had maneuvered the filing cabinet part way out of its space and was attempting to pull it further when the cabinet stuck in the carpet and Claimant felt a burning pain across the top of her right shoulder between her neck and her arm.

3. Claimant stopped working on the filing project, but continued to work the rest of the day at her desk. Claimant testified that she made a joking reference to the event to a co-worker, Janet Clark, but does not recall whether she specifically told her supervisor about the incident. Claimant worked the following two days, Wednesday, May 12, and Thursday, May 13. Claimant testified that it was on the afternoon of May 13 that she realized she had really hurt

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<sup>2</sup> The Referee notes that Defendants' brief complied with the 30-page limitation provided for by the J.R.P. only because it was prepared in non-standard (less than 12-point) type, and included a five-page, single-spaced addendum not subject to the 30-page limit.

herself and that the pain wasn't going away. Claimant did not recall whether she worked on Friday, but did recall scheduling an appointment with her physician for the following Monday.

4. On Monday, May 17, Claimant reported the May 11 incident to Employer by telling Lisa Stevens, director. Claimant reported that after May 11, the pain became increasingly worse:

I was getting burning pain right—all the way up my neck and still down into my right shoulder and my arm felt really really weak, and I was also getting numbness and tingling in my fingers. And I was having a hard time—my neck was stiffening up, I was having a hard time at that time turning my head to the right. And I was getting jaw pain and of course I had a headache.

May 20 Tr., p. 32.

#### ***MEDICAL CARE***

5. Claimant saw Jeffrey R. Pedersen, D.O., on Monday, May 17. The chart note for that date indicates that Claimant was working with the filing system the previous Tuesday and awoke Wednesday with “a lot of arm pain,” that did not improve with anti-inflammatories, Tramadol and rest. Defendants' Ex. 8. Claimant reported:

No numbness. No tingling. A little bit of neck pain on the [right] side of her neck, but no, again, shooting pains that goes all the way down [sic]. She points to her elbow, her wrist and her shoulder where most of the pain is at, especially when she tries to lift it to horizontal.

*Id.* On exam, Dr. Pedersen noted full range of motion in Claimant's neck without any difficulty, and no tenderness on palpation. Her shoulder was tender over the anterior aspect of the biceps tendon and over the lateral epicondyle. Dr. Pedersen diagnosed right arm strain and gave her prescription anti-inflammatories (Vioxx), and advised rest and ice with a recheck in a week to ten days.

6. Claimant returned to Dr. Pedersen three days later, complaining that her arm was worse. Claimant stated that the pain was radiating up into her trapezius and all the way down her

right arm. She said Vioxx was not helping. Notable on the subjective portion of the chart note for May 20 is Claimant's denial of any history of a neck injury in the past or currently. On exam, Dr. Pedersen found good range of motion in Claimant's cervical spine with a bit of tightness when she moved to the right, and some tenderness in the lower cervical area. Dr. Pedersen suspected cervical radiculopathy and ordered cervical x-rays, which showed moderate degenerative joint disease (DJD) at C5-C6. Dr. Pedersen recommended a Prednisone taper and cervical stretches, and took her off work until the following Monday. He noted:

If this does not improve at all, would recommend an MRI. Suggested physical therapy; however, given her *good range of motion* and that *she is not having a significant amount of neck pain*, I don't think physical therapy will be very beneficial at this time.

*Id.* Emphasis added.

7. Claimant called Dr. Pedersen's office on Monday, May 24, complaining that she could not work due to pain. She stated that the Ultracet was not working, and asked for stronger pain medication.<sup>3</sup> A prescription for Vicodin was called in to Claimant's pharmacy. Claimant called the office again on May 26 and advised that she could not return to work because of her pain.

8. Claimant returned to the clinic on June 1. She reported that she was improved, perhaps by 50%, though she stated that the drive to the clinic in her manual transmission car aggravated her neck and arm and caused some discomfort. She also described an occasional burning sensation at the base of her cervical spine that occasionally radiated into her shoulder and all the way down her arm. She reported that she needed only one hydrocodone per day, in the evening. Dr. Pedersen ordered a cervical spine MRI and returned Claimant to work half days

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<sup>3</sup> It is not clear who prescribed the Ultracet (a combination of Tramadol and acetaminophen), but Claimant's testimony indicated that she almost always kept prescription pain medication on hand, usually Tramadol or one of its variants.

pending the results of the MRI. He also encouraged her to resume the Vioxx, and gave her samples.

9. An MRI done June 10 found:

At C3-4, there is circumferential disc bulging which does not contact the cord. This is slightly eccentric to the right but there is no significant canal or foraminal narrowing.

At C4-5, there is no significant abnormality.

At C5-6, there is broad based dorsal disc bulge bordering on small protrusion eccentric towards the foraminal regions bilaterally. There is mild to moderate foraminal narrowing on the left and moderate foraminal narrowing on the right. No central stenosis.

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Impression:

Circumferential disc bulging at C5-6 results in mild to moderate foraminal narrowing worse on the right. No central stenosis or abnormal cord signal.

Claimant's Ex. 2, p. 049.

10. Dr. Pedersen referred Claimant to Gary Haas, D.O., for evaluation regarding cervical epidural steroid injections. Claimant saw Dr. Haas on June 22. On exam, Dr. Haas found Claimant had good range of motion in her upper extremities, that her upper extremity strength and reactions were equal bilaterally, and that there were no noted sensory deficits or any dermatomal pattern in her complaints. Dr. Haas did note marked tenderness in the right paravertebral area as well as muscle tension in the right trapezius area with numerous trigger points. Dr. Haas opined that cervical epidural steroid injections offered a reasonable treatment approach, and the first injection was administered that day.

11. On June 24, just two days after the first epidural injection, Claimant returned to see Dr. Pedersen, but he was unavailable. Instead she saw Allen M. Ernster, M.D. Thereafter, Claimant continued to treat with Dr. Ernster. Claimant reported being "acutely tender" the

morning following her injection, and told Dr. Ernster that she was supposed to work later that day but “within a couple of hours she is usually in agony.” Defendants’ Ex. 8. Additionally, Claimant had only one hydrocodone left and needed an early refill. Dr. Ernster observed that Claimant’s C3 vertebra was rotated to the right with “quite a bit of spasm around there that is readily palpable and reacts almost like a guitar string.” *Id.* Dr. Ernster diagnosed a subluxed C3 with surrounding spasm and tenderness. He took her off work for two days, and gave her Valium to help with the spasm and refilled her hydrocodone prescription.

12. Claimant returned to Dr. Ernster on June 28. She reported she was taking the hydrocodone four times per day. Dr. Ernster found tenderness in her interspinous ligament at C5-6, and paraspinous muscle tenderness, particularly between the superior aspect of her scapulae and her interspinous processes, along with increased muscle tension in her trapezius. He diagnosed cervical strain with resultant spasm and incapacity. Dr. Ernster noted that Claimant was scheduled for a second epidural injection on July 7 and given her history of tenderness post-injection, he did not want her to return to work or return to the clinic for follow up until July 13<sup>th</sup>. He gave Claimant a refill of 44 hydrocodone to get her through the next week.

13. Claimant started physical therapy with Michael F. Ward, PT, on July 1. In his initial evaluation, PT Ward opined that Claimant’s symptoms were consistent with discogenic cervical pain and guarding.

14. Claimant returned to Dr. Ernster on July 12. She reported that she could not move for two days following her second epidural injection on July 7. She told Dr. Ernster that she believed that physical therapy was beginning to help, as were the epidural injections, and she was down to three hydrocodone per day. Claimant was not taking the Vioxx because she believed it aggravated her stomach problems. Dr. Ernster started Claimant on Arthrotec, another

prescription anti-inflammatory, and recommended that Claimant wean herself off the hydrocodone. He gave her a ten-day supply of the painkiller at three per day. Seven days later, on July 19, Claimant called Dr. Ernster asking for a refill on her hydrocodone and was given sixty more.

15. Claimant saw Dr. Ernster again on July 23, July 29, and August 13. Her condition was essentially unchanged. He continued Claimant on hydrocodone and Vioxx, suggested a trial of Zoloft to try and reduce muscle tension, and prescribed Kadian, an oral form of morphine, in addition to the hydrocodone. On her August 13 visit, Dr. Ernster reviewed a letter from physical therapist Michael Ward, which indicated little progress with physical therapy. Dr. Ernster switched Claimant from Kadian to a morphine patch, and also prescribed a muscle relaxant, theorizing that Claimant's problem was related to muscle spasm and that the muscle relaxant might be more therapeutic. He also recommended Claimant return to Dr. Haas for reevaluation.

16. Claimant returned to Dr. Ernster on September 9. She advised that her current drug regimen was controlling her pain and reducing her muscle spasms. She reported she still had occasional headaches. Claimant had once again stopped taking the prescription anti-inflammatory medication, claiming it exacerbated her stomach problems. Dr. Ernster discontinued the muscle relaxant, but continued Claimant on the Zoloft and the morphine patch.

17. At the request of Defendants, Claimant underwent an independent medical evaluation (IME) by Dr. Stevens on September 14. The results of the IME are discussed in detail in a later section of these findings.

18. Claimant saw Dr. Haas on September 21. She advised Dr. Haas that the epidural steroid injections had been of some help with her radicular symptoms but that she continued to

have “fairly significant neck pain.” Defendants’ Ex. 10. Dr. Haas opined that the cause of Claimant’s pain was most likely discogenic and arose at the C5-6 level. He suggested that a discogram at C5-6 might confirm whether her C5-6 disc bulge was the source of her continuing pain. In addition he suggested she would receive better pain control from the morphine patch with fewer side effects if she changed the patch every two days instead of every three days. Dr. Haas scheduled a discogram with further treatment options, including surgery, dependent upon the results of the discogram. Surety denied the requested discogram.

19. Claimant returned to Dr. Ernster on September 30. Dr. Ernster described Claimant as “obviously very concerned and anxious.” Defendants’ Ex. 8. Claimant expressed concern over her ability to function day to day, the prospect of morphine withdrawal, and financial concerns including her husband’s unemployment and a letter regarding the termination of her workers’ compensation benefits. Dr. Ernster switched Claimant from Zoloft to Cymbalta, an anti-depressant indicated for use for nerve-related pain. He continued Claimant on the muscle relaxant, the morphine patch, and also prescribed Tramadol<sup>4</sup> as needed for headache.

20. In a letter dated September 30, 2004, Dr. Ernster wrote Surety expressing his disagreement with the IME findings of Dr. Stevens. In particular, Dr. Ernster indicated that Claimant was being evaluated by Dr. Haas and that no action should be taken until the results of a discogram were available.

21. Dr. Ernster next saw Claimant on October 21. She complained of daily headaches and reported she was taking three Tramadol a day. She also stated that the Cymbalta made her pain worse. Dr. Ernster continued the morphine patch, switched her back to Zoloft, and told her she could double up on the Tramadol if she needed to.

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<sup>4</sup> Tramadol is an opiate-based analgesic.

22. Claimant returned to Dr. Ernster on November 18, December 16, and December 30 with no notable change in her condition. Dr. Ernster gave her a starter pack for Topamax to see if that would help her headache. She reported that it did but that she could not afford to fill the prescription when the starter pack ran out. Dr. Ernster also switched Claimant to Norco, another opiate-based analgesic.<sup>5</sup> At some time during this period, he also provided Claimant with some additional hydrocodone because she was having trouble getting Surety to approve refills of her morphine patches. The hydrocodone was intended to help her control her pain while she was without the patches.

23. By January 19, 2005, Dr. Ernster reported that Claimant had lost twenty pounds, most likely as a result of the morphine patches. Claimant also reported “creaky joints,” which Dr. Ernster attributed to her inactivity. He recommended she start taking glucosamine. He also increased her dosage of Zoloft, and prescribed Amitriptyline at bedtime to help her sleep. A month later, on February 14, Claimant reported a “marked exacerbation of her pain.” Defendants’ Ex. 8. Dr. Ernster upped Claimant’s morphine patch dosage and referred her back to Dr. Haas.

24. By her March 10 visit to Dr. Ernster, Claimant was much improved with the higher morphine dosage. She expressed an interest in pursuing the referral to Dr. Haas whether or not Surety would cover the visit.

25. Claimant returned to Dr. Haas on March 31. On exam, Dr. Haas observed:

biceps, triceps, abduction, wrist flexion, extension, interdigital strength, finger flexion, supination, pronation strength all to be equal and unremarkable bilaterally. The patient claims to have some mild decreased sensory just to touch

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<sup>5</sup> The notes are not clear whether Dr. Ernster intended the Norco to replace the morphine patch or the hydrocodone. He also prescribed Clonidine in the event that Claimant experienced “withdrawal symptoms,” and discussed treating Claimant’s pain rather than her withdrawal symptoms.

over her left thumb but really do not notice any dermatomal patterns to this slight decrease sensation [sic]. DTR's, biceps, triceps, brachioradialis are all equal bilaterally.

Defendants' Ex. 10. Dr. Haas diagnosed "[m]echanical neck pain by history, probable discogenic with most likely component of radiculitis as well." *Id.* Dr. Haas provided Claimant a prescription for methadone to replace her morphine patch the next time she was scheduled to replace her patch. He hoped to add Neurontin once Claimant had achieved a clinically effective level of methadone and then gradually decrease the methadone dose. He did not change any of Claimant's other medications. On April 1, Claimant entered into a "Controlled Substance Agreement and Informed Consent" required for participation in chronic pain management care with Dr. Haas. This is the last medical record from Dr. Haas.

26. Claimant returned to Dr. Ernster on April 7 and again on May 4. The May 4 visit is the last medical record from Dr. Ernster. At that time, he switched Claimant from Zoloft to Fluoxetine because she could not afford the Zoloft prescription.

#### ***INDEPENDENT MEDICAL EXAM***

27. As discussed previously, Defendants sent Claimant to Dr. Stevens for an IME in September 2004. When asked to identify the precise location of her pain for Dr. Stevens, Claimant indicated "the right side of her neck extending into the right jaw and spasms along the anterior aspect of the right arm." Defendants' Ex. 7. She also noted numbness and tingling of the forth and fifth digits of her right hand "at times." She denied weakness in her right arm and any left-sided symptoms.

28. On exam, Dr. Stevens found that Claimant's upper extremity reflexes were "brisk and symmetrical." *Id.* Similarly, shoulder strength and rotation and elbow flexion and extension were symmetrical bilaterally. Claimant described discomfort on cervical lateral flexion, but

exhibited no reduction in lateral flexion range. Her cervical rotation was 75 degrees both left and right. Claimant reported mild tenderness to deep palpation over the right cervical paraspinals, but exhibited no palpable spasm. She had a normal cervical lordotic curve, and carried her shoulders level.

29. Dr. Stevens conducted an electrodiagnostic study in an attempt to determine whether Claimant exhibited cervical radiculopathy and, if so, to identify what levels were affected and to what severity. The results were normal, showing no evidence of either acute or chronic cervical radiculopathy from C5 through T1 on the right.

30. Ultimately, Dr. Stevens was unable to attribute Claimant's symptoms to her May 11, 2004 industrial injury. He offered several reasons in support of his conclusion, including:

- The delay between the date of injury, date of reporting, and date of medical treatment;
- The change in reported symptoms from her first reports (arm pain) to her current complaints (neck pain);
- The lack of any objective medical findings consistent with her symptoms;
- Her long term use of narcotic analgesics as prescribed by her treating physicians; and
- Claimant's experience as a workers' compensation claims adjuster, which provided her with the information and education necessary to manipulate the workers' compensation system.<sup>6</sup>

In addition to his conclusion that Claimant's current symptoms were unrelated to her industrial accident, he opined that Claimant was at maximum medical improvement, and that she needed no further treatment.

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<sup>6</sup> For much of the time she lived in Canada, Claimant was employed by the workers' compensation system in a variety of positions, including brief stints as a fill-in adjuster of undisputed claims.

31. In a letter dated February 2, 2005 to Surety, Dr. Stevens discussed his review of additional medical records from Dr. Ernster, pharmacy records, and Dr. Ernster's expressed disagreement with the conclusions in Dr. Stevens' initial report. He noted that Dr. Ernster provided no additional information, particularly objective medical information, to support his position in opposition to Dr. Stevens' conclusions. With regard to Dr. Ernster's continued call for a discogram, Dr. Stevens expressed his opinion that discograms were of questionable diagnostic benefit in patients whose pain could not be correlated with objective medical findings. Dr. Stevens stated that he carefully reviewed Dr. Ernster's notes in an effort to identify any objective findings that might cause him to reconsider his position, but found none. Dr. Stevens also responded to additional questions posed by Surety regarding Claimant's treatment. He advised Surety that he did not believe Claimant had a continuing need for prescription medication as a result of her industrial accident. He also opined that Claimant needed to be weaned off the narcotic analgesics but refused to identify who should supervise the withdrawal process, noting that while he disagreed with Dr. Ernster's handling of Claimant's case, he was not comfortable removing a patient from the supervision of the treating physician. Dr. Stevens also suggested that Claimant be immediately taken off the Norco and the morphine patch tapered to every third day for a week and then discontinued. He also pointed out that there was a new generic morphine patch available that was less costly than the Duragesic patch she had been using.

32. Dr. Stevens again wrote to Surety on February 28, 2005. He reiterated his belief that Claimant did not need the morphine patch or any other narcotic analgesic and recommended a rapid taper of the patch. Dr. Stevens was quite clear when he stated:

[Claimant] does not require any further medications beyond the tapered Duragesic i.e. no more prescribed medications of any type for her purported symptoms.

*Id.* Dr. Stevens also addressed Dr. Ernster's continued call for referral to the pain clinic as well as a discogram, restating his belief that absent any objective findings, referral to the pain clinic was not warranted, and again expressing his opinion regarding the questionable validity or utility of discograms.

### ***CLAIMANT'S PREVIOUS MEDICAL HISTORY***

33. Claimant's medical history is notable for numerous physician visits, and other treatment, for neck, right arm, and right shoulder problems and headache dating from a 1989 motor vehicle accident. Between February 1994 and November 2002, Claimant saw Brian Page, M.D., of Cranbrook, British Columbia, on at least twenty-four occasions with similar complaints, including: neck pain, headaches, shoulder pain, right paraspinal pain, right arm paresthesia, ache in right wrist, forearm numbness, and paresthesia in the ulnar aspect of the right little finger. An excellent summary of Claimant's medical history as it pertains to these particular complaints can be found in the Addendum to Defendants' Post-Hearing Brief. Over the course of his treatment of Claimant's right-sided neck, shoulder, headache and arm complaints, Dr. Page and other physicians identified a number of specific findings and proposed diagnoses for Claimant's complaints, including:

- “[F]ibroligamentous injury to the C-spine which causes ongoing neck discomfort,” resulting from a motor vehicle accident (Defendants' Ex. 11, letter to Dr. Page from Dr. Urban dated February 16, 1994);
- Straightening of the normal cervical lordotic curve (*Id.*, note dated April 26, 1994);
- Paraspinal tenderness (*Id.*, note dated June 27, 1994);
- Neck strain (*Id.*, note dated June 14, 1996);
- Tenderness in the right paraspinal and trapezius muscles (*Id.*, note dated August 27,

1996);

- Post-traumatic right thoracic outlet syndrome as a result of the 1989 motor vehicle accident (*Id.*, letter to Dr. Page from J.B. Faulker, M.D. dated January 8, 1997);
  - Stress-related headache and neck pain (*Id.*, note dated January 17, 1997);
  - Whiplash (*Id.*, note dated August 29, 2000);
  - “[S]traightening of the normal [cervical] lordosis, consistent with muscle spasm and minor osteoarthritic changes at the C5-6 level” (*Id.*, cervical x-ray report dated August 30, 2000);
  - Tenderness in right paraspinal muscles, neck, and trapezius resulting from soft tissue strain (*Id.*, note dated August 31, 2000);
  - Muscle tension headaches (*Id.*, note dated October 25, 2000);
  - Overuse injury/tendinitis (*Id.*, note dated December 7, 2000);
  - Tender right paraspinal muscles caused by neck strain (*Id.*, note dated August 21, 2002).
- Recommended treatment for Claimant’s complaints included narcotic analgesics, muscle relaxers, anti-inflammatories, anti-depressants, massage, acupuncture, physical therapy, chiropractic care, heat, ice, exercise programs, and muscle strengthening programs, singly and in various combinations.

34. While the Claimant was credible in most respects, it is evident from her testimony that her recollection of her medical history varies in substantial ways from the medical records. By their very nature, medical records are likely to be the more reliable evidence when there are inconsistencies between an individual’s testimony and the medical records themselves.

## DISCUSSION AND FURTHER FINDINGS

35. The burden of proof in an industrial accident case is on the claimant.

The claimant carries the burden of proof that to a reasonable degree of medical probability the injury for which benefits are claimed is causally related to an accident occurring in the course of employment. Proof of a possible causal link is insufficient to satisfy the burden. The issue of causation must be proved by expert medical testimony.

*Hart v. Kaman Bearing & Supply*, 130 Idaho 296, 299, 939 P.2d 1375, 1378 (1997) (internal citations omitted). "In this regard, 'probable' is defined as 'having more evidence for than against.'" *Soto v. Simplot*, 126 Idaho 536, 540, 887 P.2d 1043, 1047 (1994). Once a claimant has met his burden of proving a causal relationship between the injury for which benefits are sought and an industrial accident, then Idaho Code § 72-432 requires that the employer provide reasonable medical treatment, including medications and procedures.

36. Defendants contend that Claimant has failed to carry her burden of proving that her current symptoms were caused by the May 11, 2004 accident. Defendants base their position on three primary arguments: first, that Claimant's evidence was inconsistent and contradictory; second, that Claimant's testimony was not persuasive; and, finally, that Dr. Stevens' report and testimony provides the most persuasive evidence regarding causation.

The Referee agrees with Defendants' assertion that Claimant has failed to carry her burden of proving that her current symptoms are related to her May 11, 2004 industrial accident, though perhaps for reasons slightly different than those put forth by Defendants.

37. **Medical Records.** The Referee finds Claimant's extensive medical records from Canada to be the most persuasive and reliable evidence on the issue of causation. After a careful reading of those records, one cannot but conclude that Claimant's current symptoms and complaints are no different in their manifestation, severity, or frequency than her symptoms

following from, and attributed to, her 1989 motor vehicle accident. Although this record includes no medical records prior to 1994, the records thereafter are replete with complaints that are indistinguishable from Claimant's current complaints. Those records also include numerous imaging studies that are remarkably consistent with the more recent imaging done following the May 2004 accident. The pre-2004 medical records are also striking in that they provide little in the way of objective medical findings consistent with Claimant's symptoms. This lack of objective findings post-2004 was a primary basis for Dr. Stevens' conclusion that Claimant's symptoms were not related to her May 2004 accident.

38. Dr. Stevens' report and testimony is also persuasive in most respects.<sup>7</sup> Dr. Stevens was most troubled by the lack of objective medical evidence connecting Claimant's complaints to her work injury. Claimant clearly had observable symptoms—in particular, care providers often observed tension and spasm in the musculature of her cervical spine, upper back, jaw, and shoulder. But what impressed Dr. Stevens was that there was no acute or chronic injury or defect that could account for Claimant's complaints. Dr. Stevens did not have access to Claimant's medical records from Canada, but if he had, he would have seen a long history of similar complaints that predated the May 2004 injury at issue here.

Dr. Stevens' opinion about the utility and validity of discograms in locating and identifying the cause of pain complaints is not relevant to this decision. Had a causal relationship between the industrial accident and Claimant's complaints been proven, then a discussion as to whether a discogram was medically reasonably necessary would have been

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<sup>7</sup> Dr. Stevens' baseless assumption that Claimant's work experience in the British Columbia workers' compensation system made it likely that Claimant was manipulating the Idaho workers' compensation system was gratuitous and inappropriate, and is given no weight.

necessary. Because the Referee finds that Claimant has failed to prove such a causal connection, such discussion is left for another day.

### CONCLUSIONS OF LAW

1. Claimant has failed to carry her burden of proving that the condition for which she seeks benefits was caused by the May 11, 2004 accident.
2. Having failed to establish a causal connection between her medical condition and the May 11, 2004 accident, the issue of Claimant's entitlement to further medical care is moot.

### RECOMMENDATION

The Referee recommends that the Commission adopt the foregoing findings of fact and conclusions of law and issue an appropriate final order.

DATED this 22 day of September, 2005.

INDUSTRIAL COMMISSION

/s/ \_\_\_\_\_  
Rinda Just, Referee

ATTEST:

/s/ \_\_\_\_\_  
Assistant Commission Secretary

### CERTIFICATE OF SERVICE

I hereby certify that on the 29 day of September, 2005 a true and correct copy of **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** was served by regular United States Mail upon:

MICHAEL KESSINGER  
WHITEHEAD, AMBERSON & CALDWELL  
PO BOX 607  
LEWISTON ID 83501

GARDNER W SKINNER JR  
PO BOX 359  
BOISE ID 83701-0359

djb

/s/ \_\_\_\_\_

**BEFORE THE INDUSTRIAL COMMISSION OF THE STATE OF IDAHO**

CLARE AGUE, )  
 )  
 Claimant, )  
 )  
 v. )  
 )  
 IDAHO HOUSING & FINANCE )  
 ASSOCIATION, )  
 )  
 Employer, )  
 )  
 and )  
 )  
 STATE INSURANCE FUND, )  
 )  
 Surety, )  
 Defendants. )  
 \_\_\_\_\_ )

**IC NO. 04-510461**

**ORDER**

Filed: September 29, 2005

Pursuant to Idaho Code § 72-717, Referee Rinda Just submitted the record in the above-entitled matter, together with her proposed findings of fact and conclusions of law, to the members of the Idaho Industrial Commission for their review. Each of the undersigned Commissioners has reviewed the record and the recommendation of the Referee. The Commission concurs with this recommendation. Therefore, the Commission approves, confirms, and adopts the Referee's proposed findings of fact and conclusions of law as its own.

Based upon the foregoing reasons, IT IS HEREBY ORDERED that:

1. Claimant has failed to carry her burden of proving that the condition for which she seeks benefits was caused by the May 11, 2004 accident.
2. Having failed to establish a causal connection between her medical condition and the May 11, 2004 accident, the issue of Claimant's entitlement to further medical care is moot.

3. Pursuant to Idaho Code § 72-718, this decision is final and conclusive as to all matters adjudicated.

DATED this 29 day of September, 2005.

INDUSTRIAL COMMISSION

Unavailable for signature  
Thomas E. Limbaugh, Chairman

/s/ \_\_\_\_\_  
James F. Kile, Commissioner

/s/ \_\_\_\_\_  
R.D. Maynard, Commissioner

ATTEST:

/s/ \_\_\_\_\_  
Assistant Commission Secretary

**CERTIFICATE OF SERVICE**

I hereby certify that on the 29 day of September, 2005, a true and correct copy of the foregoing **ORDER** was served by regular United States Mail upon each of the following persons:

MICHAEL KESSINGER  
WHITEHEAD, AMBERSON & CALDWELL  
PO BOX 607  
LEWISTON ID 83501

GARDNER W SKINNER JR  
PO BOX 359  
BOISE ID 83701-0359

djb

/s/ \_\_\_\_\_